SIGNATURE ORTHOPEDICS – NEW PATIENT PACKET

INSURANCE INFORMATION

Date:_____ □ New Patient □ Update

Referred to this Office by: □ Patient □ Physician □ ER (Hospital) Name of Person/Hospital:_____

Patient's name (Last, First MI)_____DOB_____Age___Sex ____

Patient Email_____SSN_____Marital Status___Spouse's Name_____

Patient Address_____City_____State____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Patient's Employer:_____Employer's Address: _____

PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)

Name (Last, First MI)_____Relationship_____SSN_____DOB_____

Address_____City_____State___Zip_____Phone #_____Work #_____

Employer's name_____Employers Address_____

Name (Last, First MI)_____Relationship_____SSN_____DOB_____

Address_____City_____State___Zip_____Phone #_____Work #_____

Employer's name_____Employers Address_____

INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

Primary Insurance_____Effective Date_____

ID#_____Group #_____

Subscriber Full Name_____Subscriber SSN_____DOB_____

Secondary Insurance_____Effective Date_____

ID#_____Group #_____

Subscriber Full Name_____Subscriber SSN_____DOB_____

Other Insurance_____Effective Date_____

ID#_____Group #_____

Subscriber Full Name_____Subscriber SSN_____DOB_____

INJURY REPORT/NATURE OF INJURY

□ Worker's Comp □ Recreational □ Auto □ Home □ Other □ Date of Injury_____

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INITIAL MEDICAL EVALUATION

Name:_____ Date of Birth:_____

Best ph# number to reach you: _____ Email address: _____

Which is your dominant hand? □ Right □ Left Gender: □ Male □ Female Height_____ Weight_____

Work status: (check one) □ Working □ Retired □ Student □ Disabled □ Other _____

Occupation_____Employer_____

Race _____ Language_____ Ethnicity_____

Who referred you to our clinic? □ Self □ Friend □ Physician Name: _____

Primary Care Physician:_____ Cardiologist: _____

Reason for visit/Chief Complaint: Please describe injury/complaint & how long condition has been present:

_____

_____

_____

Date of onset injury/symptom _____ Is this work related? □ YES □ NO Has it been reported? □ YES □ NO

Please list any tests, xrays or therapies tried for current condition: (circle all that apply and give date)

Imaging (xrays) Diagnostic Testing, (MRI, CT, other _____)	Date Performed	Physical Therapy / Chiropractor / Home Exercise Program	Date Performed	Medications Tried:	Date Performed

Past Medical History (Please check all that apply) ☐ **NO PAST MEDICAL HISTORY**

- □ Alzheimer's disease
- □ Anemia □ Angina
- □ Arthritis
- □ Asthma
- □ Cancer Specify type:_____
- □ Congestive Heart Failure
- □ COPD
- □ Crohn's disease
- □ Coronary Artery disease
- □ Deep Vein Thrombosis (DVT)
- □ Degenerative joint disease
- □ Depression
- □ Diabetes
- □ Drug Abuse
- □ Elevated Lipids (high cholesterol)
- □ Fibromyalgia
- □ Fracture
- □ Gout
- □ Headache/Migraine
- □ Hepatitis/liver disease
- □ HIV
- □ High Blood Pressure
- □ Inflammatory bowel disease
- □ Lyme disease
- □ Myocardial infarction (heart attack)
- □ Obesity
- □ Osteoporosis
- □ Peptic Ulcer disease
- □ Psoriasis
- □ Renal disease (kidney disease
- □ Scoliosis
- □ Seizure Disorder
- □ Sleep Apnea
- □ Spinal Stenosis
- □ Spondyloarthopathy (Spondyloarthritis)
- □ Stroke
- □ Systemic lupus erythematosus (Lupus)
- □ Thyroid disease
- □ Vascular disease
- □ Other Medical Problems:

_____

Past Surgical History

Type of Surgery

Current Medications & dosage (if known): ☐ **NO Medications** *If you brought a list, please ask us to make a copy.*

Name of Medication / Strength / Directions	*Name of Medication / Strength / Directions*

What Pharmacy do you use?

Name : **Location**: **Pharmacy Ph#:**

Allergies: (Please name substance & reaction) ☐ **NO Known Allergies**
Known DRUG allergies _____
Known FOOD allergies _____
Known METAL allergy: □ Yes □ No Known LATEX allergy: □ Yes □ No

Relevant Family History: ☐ **Adopted - no family history known**

Relative	Alive	Deceased	Heart Disease	Cancer *(Specify type)*	Diabetes	High Blood Pressure	Renal disease	Thyroid disease
Father								
Mother								
Brother(s)								
Sister(s)								

Social History:
General Education: □ High School (If local, list name) _____ □ College _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Tobacco use: □ Yes □ No _____ Packs per day for _____ years Quit: □ Yes □ No Age when quit: _____
Alcohol use: □ Yes □ No Frequency/Amount: _____
Other substance use: _____
Work demands: □ Sedentary □ Moderate activity □ Heavy Labor
Do you exercise regularly? □ Yes □ No Describe: _____
What sports or activities do you participate in? _____
Do you have children: □ Yes □ No # Sons_____ # Daughters_____

PATIENTS 65 YEARS AND OLDER:
Have you had any falls in the last year? □ Yes □ No *IF YES*, Number of falls: _____
Did the fall(s) result in injury? □ Yes □ No *IF YES*, Details: _____
Do you use an assistive device (walker, cane, wheelchair, etc.)? _____
Have you ever received a Pneumonia vaccine? □ Yes □ No *IF YES*, what month/year? _____

Current Medical Status/Review of Systems: Please circle any you have had recently

Fatigue	Chest Pain	Poor coordination
Fever	Leg swelling	Muscle weakness
Night sweats	Irregular heartbeat	Seizures
Weight gain	Constipation	Tremors
Weight loss	Diarrhea	Anxiety
Blurred vision	Loss of Appetite	Depression
Double vision	Nausea	Insomnia
Headache	Vomiting	Rash
Ringing in ears	Painful urination	Skin Infections
Vertigo	Blood in urine	Skin lesions
Vision loss	Cold intolerant	Bleeding
Asthma	Heat intolerant	Bruising
Cough	Difficulty walking	Environmental allergies
Labored breathing	Dizziness	Food allergies

Name of person supplying information_____Date:_____

Signature: _____

SIGNATURE ORTHOPEDICS - SIGNATURE MEDICAL GROUP

PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to canceling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Full Name_____Relationship_____Phone #_____
Full Name_____Relationship_____Phone #_____
Full Name_____Relationship_____Phone #_____

Initial all applicable information:

___Medical/Treatment/PHI including retrieval of medical records and prescription refills
___Lab/Ancillary Testing/Radiology/MRI/Imaging Results
___Billing/Insurance Information
___Authorized to leave message on voicemail or by other designated communication systems
___Other, Describe_____

ADVANCE DIRECTIVES FOR HEALTH CARE (*Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare*)
(If applicable to the practice setting, patient to initial appropriate statement):

____The patient does NOT have an Advance Directive
____The patient has the following Advance Directive(s): _____
_____
and will provide a copy to the attending SMG physician practice

Print Patient's Full Name _____Patient DOB_____

Print Name of Legal Guardian _____Relationship to Patient_____

Signature & Date Signed _____Witness to Signature_____

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PAYMENT POLICIES

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to pay by automated payment card by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. The patient/responsible party or guarantor signing below ("you") must provide us with the patient's current and correct medical coverage/insurance/health plan ("health plan") or other responsible third-party payor.
2. You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).
3. You are responsible for paying any deductibles and co-payments in the amount specified by the health plan as well as non-covered services or other costs not covered by the health plan.
4. Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of who has the legal obligation, or payment obligation under parental custody, divorce, or separation terms.
5. WORK RELATED INJURIES:
    a. If the patient's employer has approved treatment, you will not be charged or billed.
    b. If the patient's employer does not approve treatment and <u>YOU SELECT US FOR YOUR TREATMENT</u>, you may be billed and you may be responsible for payment of services no approved by the employer.
6. If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
7. We file group health plan claims and by law, must file Medicare claims.
8. If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your statement.

We expect payment in full at time of service for all charges which are not covered by the patient's health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collection fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

All patients 18 and older must sign, regardless of whether they are on parent or other insurance.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____ Date of Birth: _____

Print Guarantor Name and Relationship to Patient: _____

Signed: _____ Date: _____

Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____